MEDICAL CARE FOR FARM SECURITY BORROWERS

Many farm families hit by the depression of 1931 had no back-log but relief. By 1935, a million farm families on relief were in desperate need of credit, guidance and encouragement if they were ever to become self-supporting again.

None of these families had equity in land on which they could get credit -- they had nothing, for the most part, except their character and previous farming experience. It was the job of the Farm Security Administration to invest in these hard-hit families. By 1939, 700,000 farm families, formerly on or near relief, had received rehabilitation loans averaging about $300 each. Rehabilitation loans enabled borrower families to buy farm equipment, livestock, work animals, fertilizer and seed.

These "character loans" were made with the understanding that borrowers follow scientific farm and home practices under the guidance of farm and home management supervisors. The supervisors worked together with the families to plan the year's budget and farming operations.

Many borrowers squeezed the full benefit out of their new opportunities of credit and guidance. Most of them are becoming self-supporting and repaying their loans. But some with the same opportunities failed.

Surveys have indicated that more than 50 percent of the families who failed to make ends meet had health problems. One farmer, for instance, on the rehabilitation program developed a reputation in his neighborhood of being "shiftless" and "no-account". While his neighbors were busy in the fields, this man lay in bed. Occasionally, he plowed a row, but would "feel porely" after this exertion. This "lazy" farmer could not hope to repay his loan or benefit from guidance given by home and county supervisors. He was nearly dropped from the program.

Investigation revealed, however, that the farmer was suffering from a hernia. He obtained a small loan from the Farm Security Administration for medical services and, today, he is successfully working his farm.

One case alone does not stand for much. When studies reveal it to be typical of borrower families who fail to make good, the case becomes significant. Too often in the past, a rehabilitation family has not made the grade because of unexpected illness.

A recent study of 100 low-income families in two Southeastern counties disclosed 1,373 ailments, including 132 cases of rickets among children; 31 cases of suspected tuberculosis; 14 cases of pellagra; 288 cases of diseased tonsils; 360 individuals with defective teeth and 124 with defective vision. Out of 109 women, 79 were suffering from tears resulting from child-birth and 21 had suspected cancer of the genital organs.

In the past, the low-income farm families aided by the Farm Security Administration had endured their illnesses matter-of-factly. Often, they allowed minor disabilities to become grave. Knowing they could not pay, families

hesitated to approach doctors. In other instances, rural doctors freely gave their services to this low-income group without any hope of recompense.

This is the picture that the Farm Security Administration is trying to change with its medical care plans which affect 128,000 families in 26 states.

In general, the medical care plans are simple enough. They are based on the borrower's ability to pay for medical services, as determined by the expected income of the family; on free choice of physician, and on the setting aside of funds at the beginning of the operating period in the hands of a trustee.

Before any medical care plan is undertaken, an agreement outlining the general principles of the program is made with the State Medical Association. Local medical societies in areas where the need seems greatest then work out the details of a medical care plan for borrower families.

The payment for participation varies in different localities from $20 to $30 per family each year. When necessary, the Farm Security Administration increases the size of its loan to a borrower to make possible his participation.

Under the plan in most general use, a certain portion of the pooled fund is set aside by the trustee at the beginning of each period for hospitalization and emergency needs, including surgery. The balance is then divided into equal monthly allotments for the period covered for payment of physicians' bills.

The physicians' monthly bills are paid in full, if possible. When the total bills exceed the amount available for a given month, all bills are proportionately reduced and each physician receives his pro rata share of the month's allotment.

Many physicians, doubtful at first of pro-rata reductions in bills, now realize that families making from $20 to $300 a year are paying all they can afford for medical care. Their doubts have been cleared up in the actual working-out of the program and physicians are co-operating whole-heartedly.

Under an alternative plan, funds are not pooled, but are kept separate for each family. This plan does not provide for hospitalization, and it is gradually being dropped in the two states in which it is now operating.

Experience has proved that the pooling of funds has been more satisfactory for low-income families. No family in this income level can pay individually for hospitalization and special medical care without financial ruin or without destroying the hope of solvency for years to come; yet, it is unfair to ask a physician to handle such a case for a fee which does not cover long and special attention. The pooling of funds serves as a form of voluntary insurance against disaster for the patient and against unreasonable hardship for the doctor.

Practical application of the program in rural areas has also dispelled doubts about the workability of a plan which sets aside sums for medical care when no illness may occur in the family during the year. Most families receive

some medical care, and feel that the security of the plan is worth the investment. Nor, are families abusing their privilege by requesting unnecessary attention to any great extent.

The medical care program embodies principles worthy of note. It encourages an acceptance of preventive medicine and it bases payment for medical care on the expected income of the family.

The bulk of medical care plans operate on a county basis in the states of Alabama, Arkansas, Colorado, Florida, Georgia, Idaho, Indiana, Iowa, Kansas, Louisiana, Mississippi, Missouri, Montana, New Jersey, New Mexico, North Carolina, Ohio, Oklahoma, South Carolina, Tennessee, Texas and Virginia.

In North and South Dakota, the medical care program which was begun by small grants to individuals in 1935 has developed into state-wide programs. The economic conditions of the farm families in these two states was acute. Recurring seasons of drought had "burned out" half the farming population. Thousands of families migrated to California and the Northwest in search of work; others remained hoping that rain would come again.

Those that remained could barely exist on what they made; there was no surplus to pay for medical attention. About 77,000 farm families received help from the Farm Security Administration in the two states.

About 45,000 of these families are now participating in the medical aid programs in these two states. They are members either of the North Dakota Farmers' Mutual Aid Corporation or of the South Dakota Farmers' Aid Corporation. Membership in either of these Corporations assures the family of medical attention for emergency, but not chronic conditions. They also have free choice of any physician licensed to practise medicine in the state who is co-operating in the program.

Although a monthly fee of $2.00 a month per family for a minimum period of 8 months was customary in the past, this fee will probably be raised to an average of $2.75 a month because of unprecedented demand for medical services in the past year.

Funds are pooled and monthly bills for emergency medical and dental care, for emergency hospitalization and for prescribed drugs and necessary medical supplies are paid by the Corporations on the basis of a special schedule of fees.

In California and Arizona, a health association has been established by the Farm Security Administration with the co-operation of the State Relief Administration, the State Health Department and the State Medical Association. The object of this Association is to furnish medical care and to check the spread of disease among migrant workers.

Since June, 1935, more than 220,000 refugees from the drought states and the South have migrated to California in search of work. With the influx of these indigents living in ditch-bank "jungles", in patched tents, or hastily-erected

shelters of packing cases, a problem in public health and welfare was created.

The recurring risk of contagion and infection being widely spread by the migrants to neighboring communities and the high morbidity rate among the migrants themselves made imperative a program of medical aid to these workers.

The Farm Security Administration does not believe that its program of medical care is a final answer to the question raised by the need of medical aid in rural areas. Adjustments and changes will be necessary as experience tests the program. It is felt, however, that these medical care plans are examples of methods which may be used to advantage in approaching the problem of medical aid.

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